Welcome and thank you for standing by. All participants are in a listen-only mode. Today's conference is being recorded; if you have any objections, please disconnect. Now I'll turn the meeting over to Mr. George Lamb.

You may begin.

Thank you.

Good afternoon and thank you for joining us today for our May webinar. My name is George Lamb. I'm the Outreach Division Chief for the Defense Center of Excellence for Psychological Help and Traumatic Brain Injury. I will be your moderator for today's webinar.

Before we begin, let's review some webinar details. Live closed captioning is now available through the Federal Relay Conference Captioning. Please see the prompt beneath the presentation slide.

Today's webinar is hosted using the Adobe Connect and Defense Connect Online platforms. Should you experience any technical difficulties, please visit <a href="www.dcoe.health.mil/webinar">www.dcoe.health.mil/webinar</a> to access troubleshooting tips. There may also be audible delays as advance in slides. Please be patient as connection catches up with the speaker's comments. During the webinar, you are welcome to submit your technical or comment-related questions via the Question Box located at the top left of the screen.

The Question Box is monitored, and questions are forwarded to our presenters for their response during the Question and Answer session during the last half hour of the webinar. Our presenter and I will respond to as many questions as time permits. DCoE awards Continuing Education, or CE credits, is limited in scope to health care providers who actively provide psychological health and traumatic brain injury care to active-duty U.S. service members, reservists, National Guardsmen, military veterans and/or their families. To qualify for the receipt of CE credits from the St. Louis University, you have had to have registered prior to Monday, May 13, 2013, at 11:59 p.m.

At the end of the DCoE webinar, participants will be provided with the URL and the date that the webinar to obtain CE credits will be open and closed. All who registered prior to the deadline on Monday, May 13, 2013, at 11:59 p.m. are eligible to receive a certificate of attendance.

The authority for training of contractors is at the discretion of the chief contracting official. Currently, only those contractors with scope of work or with commensurate contact language are permitted in this training. This webinar is approved for the following CE credits: 1.5 AMA PRA Category 1 credits, 1.75 Continuing Educational Contact Hours Physical Therapy and Occupational Therapy, 1.5 Nursing Contact Hours, 1.5 Social Work CE hours, 1.5 APA Credits for Psychologists. For complete accreditation statements, visit www.dcoe.health.mil/webinars.

If you were preregistered for this webinar and would like to obtain a Continuing Education certificate, you will need to complete the online CE Evaluation. At the Swank Healthcare website listed, you will be asked to complete the online CE Evaluation and download your Continuing Education certificate. The Swank Healthcare website will remain open until Thursday, May 20, 2013, at 11:59 p.m. Eastern Standard Time. If you did not register, you will not be able to receive Continuing Education credits or a certificate of attendance for this event.

I will now move on to today's webinar topic, Psychological Health Issues in the National Guard and Reserves: Prevalence, Barriers and Treatment. Reserve components, which are National Guard and Reserves, service members play a vital role with more than 123,000 reserve component service members activated in Operation Enduring Freedom/Operation Iraqi Freedom missions. Reserve components face many challenges active components do not. For example, reserve components transition from military to civilian life frequently, balancing the demands of both military and civilian life. Research has suggested that reserve components may have different health concerns, psychological or physical, compared to their active components.

This webinar will examine the various psychological health problems experienced by reserve components, identify challenges facing reserve components to accessing care, present treatment recommendations for working with the reserve components.

Today's main presenter is Dr. Tracie Shea. Dr. Shea is currently a Staff Psychologist and Director of the PTSD Research at the Providence Veterans Affairs Medical Center, Rhode Island, and is a Professor in the Department of Psychology and Human Behavior at Brown University. Dr. Shea has conducted research on Posttraumatic Stress Disorder, Personality Disorder and depression. Her most recent research on PTSD includes a randomized study of treatment for anger problems in veterans of Iraq and Afghanistan. This study examines the early longitudinal course of PTSD symptoms and predictors of chronic PTSD in veterans of the Iraq war.

Dr. Shea is currently a co-investigator of the two studies on the treatment of relationship conflict in veterans. Dr. Shea previously participated as an investigator in two large multi-site clinical trials to examine the effectiveness of exposure-based treatment compared to supportive, present-centered therapy for the treatment of PTSD in veterans. She was also the principle investigator for a ten-year study of the naturalistic longitudinal course of personality disorders.

Welcome, Dr. Shea.

Thank you, George.

It's great to be here, and I'm looking forward to speaking with all of you on this new technology. So just moving right in, the disclaimer – I have no relevant financial relationships to disclose.

So just a little bit of background, which you've already heard some about, somewhere around 2.3 million service members have been deployed as part of OEF and OIF. The statistics I've seen most recently are somewhere around 665,000, or 29% of the National Guard or Reserve. And at its highest point, the National Guard and Reserve constituted about 40% of the total deployed.

So there are a lot of things, as I'm sure you're all familiar with, that are unprecedented in terms of the current wars in Iraq and Afghanistan. These are not all specific, of course, to National Guard and Reserve; and that's what I'm going to try to focus on. But just as general background, deployments have often been longer than in the past. Many people have multiple deployments; the breaks can be short; and again, most importantly for the talk today, a larger proportion of overall deployed troops are National Guard or Reserve.

Next slide -- so this just illustrates in terms of numbers – this is not percent – but rough numbers of deployed National Guard and Reserve in some different wars. And what's very striking is the much larger number for OEF and OIF comparing to Vietnam, for example, where I believe about five million people were deployed over the course of that war. So actually, more than twice as much as in OEF/OIF in the number; so you really see a striking difference. So this is really unprecedented.

Can I have the next slide?

So the objectives here, as you've heard, is I will focus on the questions that were asked which are to take a look at post-deployment psychological health problems experienced by National Guard and Reserve members, identify challenges for accessing care, and then finally to discuss treatment considerations and recommendations for working with National Guard and Reserve members. And again, I've tried to focus this talk as much as possible on things that may be unique to National Guard and Reserve; but some of the points really apply more broadly.

Can I have the next slide?

So this is just an overview. I'm going to start out talking a little bit about nature of stressors just to provide, again, that background. Then I'll move on and talk about the psychological health problems: PTSD,

depression, substance abuse, anger and aggression, interpersonal conflict, relationship problems and then the general issue of reintegrating into civilian society.

#### So the next slide?

And then we'll move on and talk about what the studies have shown in terms of proportion of people who are using the mental health services and then some of the barriers to access and care. And then finally, we'll talk about some treatment considerations including different treatment approaches and issues involved in engagement and rapport and so forth.

#### Okay, so next slide?

So nature of the stressors in the warzone – I think again people are probably pretty familiar with these, but I find it useful to just discuss in terms of, again, providing a backdrop and reminding us of where some of these problems come from. And this is one that often is not paid much attention to – it's not as dramatic – but certainly there's some probably considerable stress for living and working environments while deployed. There can be lack of privacy, uncomfortable climate, sometimes boredom, and then sometimes the opposite extreme – physical exertion and exhaustion. So those are sort of background, often, factors that are going on.

#### And then the next slide?

And this is what I think we typically think of in terms of stress in the warzone, which is one's personal risk of injury or death – the fear of getting hit; the ongoing threat of attack by mortars, rockets, small arms, snipers; IEDs, which of course have been huge in the wars in Iraq and Afghanistan; suicide bombers; and also the fact that it's urban warfare. I think there's this sense of – for many – of never being safe really, of having to be vigilant all the time, perhaps more than in some of the prior wars.

#### Next slide?

And then this of course is another dimension that I think is worth separating out. As opposed to worrying about one's own risk of injury and survival, it's witnessing injury, suffering, death, violence and so forth of kind of horrible things that do happen in a warzone. So that can include seeing close friends who have been seriously injured or killed; just seeing death on a large scale – enemy and civilians; just seeing the aftermath of battle -- particularly sometimes with these IEDs and so forth, you can really have horrific injuries and mutilated bodies and so forth; handling human remains, which is not unusual; and then just the general witnessing of violence.

#### So the next slide?

And then finally, to separate another dimension is the fact that what war involves is killing and one's personal experience that many have, not all, but of having to inflict injury and death on others – including not just the enemy, but sometimes civilians in friendly fire.

So that's sort of the backdrop as a reminder of the kinds of things that are going on that contribute to some of the issues that people are dealing with when they come back.

On the next slide, this is related to the last point. This is a quote -- I found this years ago, 2004 – from an Army chaplain outside of Mosel who was doing a lot of counseling of soldiers. And in terms of the kinds of stressors that people experience, this quote captured a lot of it I thought. "There are usually two things they're dealing with – either being shot at and not wanting to get shot at again – or after shooting someone asking, 'Did I commit murder?' or "Is God going to forgive me?'" So it again highlights those different dimensions of stress.

Okay, next slide, please. That would be Slide 20.

So what might be more not unique, but additional for members of the National Guard and Reserve who are deployed? Well, one possibility is because they're not full-time military, they're just "citizen soldiers," it's possible that some of them may feel less prepared for active duty. They may not be as used to it.

They're more likely to have family and civilian work responsibilities – family because on average, they are older than active duty so more of them have families.

A third is that I think historically there's been less support for families while they're deployed. I think this may be changing. I know the National Guard at least has made a lot of efforts to increase support for families at home before, during and after deployments. But I think historically there's just been less of an infrastructure for providing that kind of critical support.

Another point is that often they may be returning to communities that have less awareness or appreciation of military service. And that may be true in some places more than others, but there really is a walking back into civilian society where life has been going on that perhaps for National Guard and Reserve folks might be more striking because they are literally walking right back into that civilian world.

Next, please.

And then additionally, not being embedded with military units after deployment -- I mean, they do have their follow-up weekend drills and so forth, but it's not the same as being on a military base. So it's again possibly lower levels of post-deployment support.

And then finally, the jobs aren't always there when they come back; so there are often financial stresses and strains that perhaps are more burdensome for National Guard and Reserve.

Okay, so the next slide?

So I'm going to move on now and talk about the psychological health problems that are most commonly reported on for these populations.

Next, please?

Another quote that I like because I think often we just, in terms of consequences of trauma, we often just think PTSD because that's kind of been associated now with the effects of severe trauma. But this quote kind of gets beyond that: "We have begun to appreciate the profound and sometimes irreversible changes produced by overwhelming stress. These include fundamental alterations in perception, cognition, behavior, emotional reactivity, brain function, personal identity, worldview, and spiritual beliefs." That is by Matt Friedman in an editorial; I think it was in 2005; and the reason I again emphasize it is because it is wide-ranging and it's not uniform for every individual.

Next slide, please?

So I'm going to talk in the next few slides about the prevalence of the mental health diagnoses and symptoms that are listed here: PTSD, depression, alcohol misuse, and anger and aggression. And this is not, I should say, a systematic review; but I focused on some studies that either had large samples that were less likely to be convenience samples, but large samples sometimes randomly ascertained, and if they tended to focus specifically on National Guard and Reserve or provide a comparison between active component and National Guard and Reserve. So I think they're probably pretty representative; but again, it's not a systematic review.

So starting with the next slide, I'll say first that prevalence rates often vary across studies because there are often different measures that are used. There are different ways of defining cases – PTSD, depression, etc. The timing of the assessment seems to make a big difference, whether it's right after return or whether it's 3, 6, 12 months after return. And clearly, the frequency of symptoms and disorders

and so forth is going to depend on the amount of combat and trauma exposure; and that varies over time. So there are a lot of factors that go into it, so there's no clearly magic number.

But with that in mind, we'll move on to the next slide.

These are two studies that I've pulled a lot of this data from; and I'll try to summarize them, hopefully clearly or succinctly as much as possible. One was by Milliken, published in 2007, that looked at – well, I'll get into the details in the next slide.

The Milliken study – again, large sample, over 88,000 soldiers returning from Iraq -- the data was collected here at the Post Deployment Health Assessment, PDHA, and reassessment, PDHRA, with the latter being a median of six months following the initial PDHA – so about six months later. Their sample consisted of 56,350 active components and also a sizable number of National Guard and Reserve – 31,885.

And another point to mention here, some of the time these surveys or measures are anonymous and sometimes they're not, which could impact reporting. So in this case, because they were PDHAs, they're not anonymous; so that's something to keep in mind.

So, next slide.

So this shows the positive screen. So this doesn't mean a disorder of PTSD; it's just that probability estimate based on a positive screen of a short measure. And what you can see from looking at the slide with the active component on the left and National Guard and Reserve on the right, the most striking thing is that – well, first of all, for both active and National Guard and Reserve, there's an increase in the prevalence of positive screens from the initial PDHA to the follow-up PDHA. And the other thing is that that increase is larger for the National Guard and Reserve than it is for the active component.

So, next slide?

Same pattern for depression – the prevalence is lower, but it's exactly the same pattern as the other slide. There's an increase for both, but the increase tends to be larger for the National Guard and Reserve at six months.

Okay, so Slide #30?

Just doing a summary across the two time points for the same study by Milliken, again comparing active and National Guard and Reserve – so you can see that there's – first of all, let me mention the positive alcohol screen. It's slightly higher in National Guard and Reserve, but not hugely so. But looking at any mental health problem combining all of those, you have twice as high – and again, collapsing across the two time points – you have twice as many who screen positive for a mental health problem in the National Guard as in the active component. And consistent with that, you have more than twice as many that were referred for mental health care.

So, next slide?

So I'm moving on now to the second study, which was by Thomas and colleagues, published in 2010. Again, this study compared active and National Guard. In this study, it was at 3 and 12 months post-deployment. The surveys were anonymous; and again, it was a pretty large sample -- not as large as the other one, but still pretty substantial – over 13,000. Another goal of this study was to adjust that problem of different rates by looking at different case definitions.

So I could have the next slide?

So on the left – in terms of the different case definitions, he looked at meeting criteria for PTSD according to self-report measure, the PCL – PTSD Checklist. So it was a bit more comprehensive and longer than in

the Milliken study, but also added functional impairment into the case definition. So on the left, you see that the proportion of individuals reporting symptoms of PTSD by DSM4 that would meet the diagnosis and also reported at least some functional impairment, which not all studies ask about. And interestingly, you see the same pattern as in the Milliken study – that you have increases from the first to the second time points, and that the increase seems to be larger for, again, the National Guard and Reserve -- so at highest here being about 29% for National Guard and Reserve at 12 months.

So this is again going out further – 12 months as opposed to the last study, which was 6 months. So it looks like they're continuing to increase. And this was an anonymous survey. One of the questions that can come up clearly if it's not anonymous, is "What is the impact on reporting? Does it make a difference?" And seeing the same pattern is somewhat reassuring, although the numbers can be different which we'll get to in a minute.

So looking on the right, it's really the same basic slide except it's the proportion who have serious functional impairment. So up to about 11% or 12% of the National Guard and Reserve reports serious functional impairment associated with PTSD at the 12-month point, and that again is pretty substantial but certainly far less than a lot of the other reports where they are either not measuring impairment or just have moderate.

Let me see – next slide, please.

Okay, so reporting on depression, one of the other common symptoms that can arise – and again, these are estimates based on self-report measures – so again breaking it down by the functional impairment, one thing that's different about depression as opposed to PTSD is that the National Guard group as a whole does not have higher rates of probable depression. You can see they're actually slightly higher in the active component.

You do see again though this increase from 3 months to 12 months for the National Guard and Reserve -- so again, this kind of consistent pattern, whether it's some functional impairment or whether it's serious functional impairment on the right. You see this increase as time goes on for the National Guard and Reserve, which is sometimes present but not always present for the active component troops. But again, depression does not separate the groups the way that PTSD did.

Okay, so next slide, please.

So this is just a summary of depression or PTSD in the Thomas study. So if you collapse them, you see a somewhat higher rate for the National Guard and Reserves.

Okay, so the next slide?

Okay, so getting into alcohol misuse, in this study – again, this is the Thomas study, the anonymous survey – you see not an increase, but you do see the National Guard and Reserve having higher rates of 14%-15% compared to about 10% to 12%. And interestingly, there's an decrease in the active component from 3 months to 12 months – not huge, but it goes in the other direction as opposed to the typical pattern that we have seen.

Okay, so next slide.

Just a summary – I've been putting a lot of slides out there with lots of different graphs and numbers. So you can see a range of estimates of these mental health problems. For the National Guard and Reserve across the studies and across the time points, we find anywhere from 7% to 29% who are estimated as probable cases – so were possible cases of PTSD. Depression is lower – from 5% to 15%; alcohol misuse – 10% to 15%; and any mental health problem at all, 42%. So those are kind of the numbers from those two large studies.

So moving on in the next slide to talk about a very different kind of study – this is a study that I did with my colleagues. Typically, we focus on these kinds of categorical estimates of PTSD, yes or no; depression, yes or no, and so forth. So for PTSD, we looked at a somewhat different question. This was a sample – a much smaller sample – of 238, but totally National Guard and Reserve that we recruited from the PDHAs and PDHRAs. And so self-report measures, we used the CAPS, which is a structured interview which is very comprehensive probing and readings of symptoms. And then we had some repeat assessments over time.

#### So, next slide?

So what we found – and this is reporting out of everyone. This is not just people with Posttraumatic Stress Disorder diagnosis. In fact, we found that only about 10% of our 238 people met full criteria for PTSD by DSM4 based on the CAPS at the point at which they came back or over the course of the study.

But if you just look at the symptoms that are present -- this would be the first month following return – we found that they were not uncommon. 17% were reporting nightmares. There was also some distress reminder. So the re-experiencing symptoms were there, but not in huge numbers.

#### And then the next slide?

Numbing and avoidance – about the same – the highest proportion were in the "feeling detached and estranged" and "restricted affect," that kind of numbing where actually about one in five were reporting experiencing that. And to be a positive on the CAPS for this symptom, they had to be reporting at least moderate impairment associated with the symptom.

#### Okay, so next slide?

What was most striking was – and this might not be surprising – but the hyperarousal symptoms were very common, ranging from concentration at 21% all the way to 55% for hypervigilance. Also irritability and anger was quite high at 50%; sleep, 43%; startle, 43%. So you kind of look at this and you think, "Well, maybe that's not surprising; they have just come from a warzone, and you would expect that there could be still a lot of hypervigilance.

And some of these, again, symptoms just would seem to make a lot of sense in the context of having had the experiences that they've had. So one question is – again, this is not people with PTSD but just the whole sample as a whole – do they persist or do they kind of just reduce over time – sort of normalize?

So if we look on the next slide, this shows the prevalence of these symptoms or the frequency of these symptoms at month one and month six. And what you can see is that they are pretty close – the curves are very close; and we didn't see much decrease from month one to month six. You see on the left are the re-experiencing symptoms that are followed by the numbing and avoidance in the "C" figures. And then of course it's the hyperarousal symptoms as a whole that tend to be more frequent. And you just don't see much change except for startle response seems to go down a little bit.

And then the next slide, looking at 12 months, we see a similar pattern; although there does seem to be some decrease. And I think this would be the anger and irritability, I believe; and this is the hypervigilance. So the ones that were the highest start to decrease a little bit, but also the sample is smaller at this point. So it's possible that there's some selective attrition; that's a little difficult to tell.

But at any rate, in the next slide – just to summarize it, first of all, again, I'm just repeating these points – the main points – rates of PTSD and any mental disorder tend to be higher in the National Guard and Reserve than the active component. A second thing that's pretty consistent is the rates tend to increase with later assessments. And a third point, that the increases over time for the National Guard and Reserve tend to be larger than for the active component, although that's not true always; but it's certainly consistent for PTSD.

And then finally, we found that hyperarousal symptoms are very common and persist even in those who do not have PTSD.

Okay, so the next slide?

I'm going to talk a little bit about what some of the findings are for anger and aggression. Okay, so here I'm on Slide 45 now. This is the Milliken study, which as you might remember is not anonymous. And the data came from the PDHA and the PDHRA. So first of all, we see a similar pattern in terms of the increase for the National Guard and Reserve. It looks bigger than it is; it goes from 2% to 4% because overall the numbers are actually pretty small here. Only 4% at most reported that they were having thoughts of or concerns about that they could be aggressive towards someone else. So it's just ideation; it's thoughts; it's not actual behaviors. But the rates are actually pretty low.

So if I could have the next slide?

Now, this is the Thomas study, which was anonymous. And what's pretty striking is right away, you see that the rates are much higher. It could well be that in the other study, the Milliken study, that there were some reservations about reporting aggression. There could be reservations about reporting any mental health symptoms, but it might be that particularly aggression there would be some concern about reporting. And these are certainly higher.

It's a different measure; instead of ideation, it's looking at actual actions. So the proportion of individuals who reported that they had kicked, smashed or punched something was actually higher in the active component, interestingly. So that's a very different pattern, but it was all the way up to 43% at the three-month point. It's also different and then that decreases at 12 months; so that's a different pattern. It's lower for the National Guard, but you do again see that typical increase for the National Guard from 3 months to 12 months, but overall not as many are reporting that particular aspect of aggressive behavior.

The one on the right is people reporting that they actually got into a fight and hit someone – more serious aggression. And there the numbers are actually higher than I would expect, at close to 20% for the active component – a little bit less for National Guard and Reserve, lower certainly and some more serious behavior but still not infrequent -- and again, this sort of small but consistent increase for the National Guard and Reserve from 3 to 12 months.

Okay, so the next slide?

So another study reporting on anger and aggression. I'm just giving you a range here. This is a sample of 724 OEF/OIF combat veterans receiving VA medical care. So I'm moving out of the post-deployment samples into the VA samples here. This is a study by Sayer and colleagues in 2010. So these are people that are coming to the VA, so it's not representative of certainly the whole deployed National Guard and active component. But these are people that are at the VA not necessarily for mental health; they might be, they might not be.

But of all those who were sampled – and this was a randomly selected national sample – 57% reported more problems controlling anger than they had had before. And actually 35% reported that their thoughts or concerns about hurting someone, and that's the median of 42 months; so it's like three and a half years post-deployment. So it looks like some of these issues are really persisting, at least in some, in the sample of the people that have gone to the VA for health care services. So it's common.

The next slide?

And a logical thing to follow from anger and aggression is interpersonal conflict and relationship issues. So we'll take a look at some of those numbers.

So the next slide?

Again, we're in Slide 49 now. This is the proportion that's again the Milliken study – PDHA/PDHRA. And you can see again a very familiar pattern, which is that the National Guard and Reserve bigger increase, higher rates at the second assessment – so at six months – with up to again over 20% at six months for the National Guard and Reserve reporting interpersonal conflict. This again is not anonymous.

Are those real differences between the active component and National Guard and Reserve? It's hard to say because it could be that there are more reservations about reporting among the active duty individuals than National Guard and Reserve – perhaps more concerns about military career and so forth. But that's speculation; we really don't know.

So, next slide?

Again, I'm going to a different sample, not as big. But the point is just to emphasize that different studies from different perspectives have report in this case among a sample of National Guard soldiers – not a large sample – but still high rates of concern. So clearly, 74% concerns about getting along with spouse or partner. And again, these are not people who were recruited for having a mental health problem. They're just of the sample as a whole. So in some samples at least, you can see again that this is an issue that really needs attention -- that it's common.

So, next slide?

Same thing, same point -- this is the VA sample that I just talked about. An average of almost four years – three and a half years after deployment again reporting pretty high proportions of problems getting along with others.

Okay, so next slide?

And then this is a somewhat different take, but this is something I think among those of you who have worked with individuals from the National Guard and Reserve or probably active component as well, is really common that this difficulty in getting back into civilian society. And this is the only study that I am aware of – could be others -- but this is the only one I've seen that actually tried to assess that. This is again in the VA sample – not necessarily mental health problems, but where you have close to half reporting that they're have some problems in getting involved in community life while being in civilian society, finding meaning or purpose in life. And these are just sort of the general kind of reintegration issues. And again, this study was about -- the sample was about three and a half years post-deployment; so it's not something that's just initial. It's something that seems to be persisting, at least for this VA sample.

Okay, next slide?

Another summary – so we see it's common. The prevalence rates are fairly high for PTSD, depression, alcohol problems. You see at least in some of the studies that they're reporting increased difficulty controlling anger and aggression. We see conflict in relationships by the report is not unusual, including spouse, partner, children -- this sense of feeling alienated from society and civilians. So that's a summary of the psychological health problems, just to get a sense of the scope – at least as reported in the literature.

So if we move on to the next slide, I think we go into – oh, one more point there to emphasize that the findings again suggest that some of these problems may be more frequent in National Guard.

Okay, so now moving on to the next slide – so these problems are there. Are our servicemen and women using mental health services? Big question.

Let's look at the next slide.

I'm going to show you data again. I hope I'm not showing too much data. I'm starting to summarize the main points. But looking at military samples – also looking at a few randomly-sampled national surveys and then some national VA databases – so similar, but you could expect different questions or findings from these different kinds of samples.

So, next slide?

Okay, so this is the first study. This is by Hoge in 2004. This is the first big study that reported on mental health problems and issues in returning – in this case, it was soldiers and Marines, active component. And also, he and colleagues reported on the proportion who received professional help first of all from any professional. So this is of those who screened positive for PTSD, anxiety or depression. How many of those reported receiving professional help from any professional? And it ranged from 23% for those who had been deployed in Afghanistan. At that point in time, Afghanistan didn't have the extent of combat exposure as Iraq, although that's probably changed now. But 29% of the Marines who were deployed in Iraq and then 40% of the Army actually received some professional help.

If we look at the next slide, this is just those – the same studies – but just the proportion who received professional help actually from mental health professionals. So the other slide included things like chaplains and primary care doctors and so forth. If you look at actual mental health professionals at that point in time, it was lower – 21% to 27% -- and again, this is of those that were screening positive for PTSD, anxiety or depression – so really not as high as one would like to see. This was early. I mean, this was published in 2004; so this was very early on in the Iraq war.

So looking at the next slide, this is a later study by Hoge – two years later. And this was Army and Marines again completing the PDHA, so this one was not anonymous. And after the survey where they looked at those who reported symptoms consistent with PTSD, depression and so forth, they looked at one year later how many had actually sought health care utilization – one year after return. And they found first of all, just looking at all whether they had screened positive for a mental health issue or not, 35% actually utilized some mental health care in the year following. So that's interesting; it's higher than one would expect.

Of those that were referred for mental health care – in other words, those that were screening positive – about half utilized mental health care. So one point that they made is that many of those who ended up getting care actually were not referred, which could be a reporting factor -- you know, people underreporting their symptoms. So again though, about half of those screening positive that were referred for mental health care actually followed up and got some care.

So, next slide?

This is another study which was a survey, and the numbers are lower here in terms of those who were screened positive. It's not clear why, but they do show both active duty and National Guard. This is a study by Kim and colleagues. And again, the pattern that we've seen before is there too – somewhat higher for the National Guard and Reserve.

So, next slide?

I'm going to move more guickly through here because I want to make sure I get to some of the others.

I think that – yeah, let's just go to the next slide -- another sample showing somewhat higher rates from a VA sample of people who utilize mental health care.

And then the next slide?

So again, VA sample about half who received a mental health diagnosis.

And then the next slide?

So this is the Seal et al study. Again, at least one mental health visit within the first year of diagnosis. And these numbers are actually higher, which is reassuring. Again, this is a VA sample; and they received a mental health visit within the first year of being diagnosed. So those numbers are actually pretty reassuring. It's a later study – 2010.

The next slide?

This is the point I wanted to get to. Of those who even if they did have a mental health visit, they weren't seeming to get enough. If you looked at the proportion who had at least nine sessions within 15 weeks – now, that would be ideal because you want to have intensive early treatment – so if you look at it that way, it's not as encouraging. Under 10% actually had that frequency of sessions.

If you expand it to a year, it gets higher – nine or more sessions, 27%; but the median number of visits in the first year of treatment were four. And that's with a PTSD diagnosis, so that's kind of disappointing.

This is another slide that just suggests – this is just a small sample – but it suggests that compared to the Vietnam veterans that OEF/OIF weren't staying in treatment as much. They were dropping out more and completing proportionately fewer of the sessions that were scheduled.

So, next slide?

To just try to summarize this, it looks like somewhere around half of OEF/OIF veterans with mental health problems seek treatment. Rates again may be higher in National Guard and Reserve. But again, there seems to be this under treatment even among those who go. So that's something that needs to improve to really make sure that people get adequate treatment. First of all, more people need to get into treatment; and second, they need to have sufficient levels of treatment.

So, the next slide?

I'm going to just go through a little bit about the report – why people aren't getting care. Stigma is often cited as an important reason. There can be beliefs about mental health treatment that do not work favorably for getting into care. And then access is another important point.

So, next slide? We're on Slide #69 now.

So how about stigma? This is the Hoge study again – big sample. And you can see stigma was certainly alive and well there. This is among people with any mental health disorder who reported reasons for not seeking treatment – embarrassing, hurt career, be seen as weak, and so forth – was very common. Interestingly, not shown here, but of those who did not screen positive for a mental health disorder, these proportions were lower. So it was really for those who did screen positive that had the higher concerns about the stigma.

Next slide?

Also a fair number did not trust mental health professionals or didn't believe that mental health care would work.

Okay, so the next slide?

How about access barriers? At this point – and again, this is early, 2004 – the access problems that were the largest were difficulty getting time off work and difficult to schedule appointments. So there was some perception that it would just not be feasible. They were the most common – or not knowing where to get help too.

So, next slide?

This is another study comparing the active and National Guard stigma issues. Again, they tended to be fairly frequently, but they were lower in the National Guard and Reserve. So that's good news for the National Guard and Reserve, that somehow the message that getting treatment – it's not seen as as stigmatized as in the active component, at least in this study – but still, more than we would like to see reported.

So, next slide?

Again, these are kind of access barriers – lower again in the National Guard for some of the items, not all. But again, difficult to get time off of work is one of the most frequent reported for both groups but again, not as high as in the other study. So it seems like the access barriers were decreasing to some extent.

And then the next slide?

It does seem from these data that stigma might be decreasing, but it's still important – maybe less important for National Guard and Reserve. And that issue about getting appointments and getting time off of work seems to be the one that gets in the way in terms of practical concerns.

So, next slide?

So I wanted to make sure we had some time to talk about some thoughts about treatment considerations. So focusing on some of these issues that seem to me to be important – both coming out from the data as well as just more generally – one issue that we've seen is it seems to be difficult to keep some OEF/OIF veterans in treatment. With just even clinical experience in our clinic, we see some of that; they're not as likely to stick as some of the Vietnam members – that one study that was consistent with that.

Another issue that I just wanted to focus on briefly was that we know that aside from severity of trauma exposure, the two most consistent predictors of PTSD include social support and life stress. That shows up in study after study. So that's clearly an important variable to pay attention to.

I want to talk a little bit about the effective treatments for PTSD, a little bit about marital strain and conflict, a little bit about guilt and anger and aggression.

So, let's see - Slide #77.

So in terms of the first point, clearly the issue of engagement and rapport has got to be important. So in terms of engagement, certainly flexibility in scheduling appointments -- nights and weekends are important because this population tends to be working and they can't often make it otherwise. And certainly to be alert to negative perceptions about mental health treatment -- a lot of these individuals come from a background where they wouldn't be thinking about mental health treatment for themselves. They're not used to it. They may not know people who have had mental health treatment. And they just may not have positive perception. So it's important to be sort of tuned into that. I wouldn't bring it up unless it was apparent, but it seems like it's an important thing to be alert to.

Another point is the whole issue of after being in a deployment one, two, three – however many – does this person, if they're a civilian provider, as so many of us are, do they have a clue what we're talking about? That's I think a key issue. And so clearly showing familiarity with the military culture and the kinds of experiences that deployed veterans have is important. And obviously, if you've been working with these individuals a lot, you know it and you see that. But for somebody who's newer, I'd say that's an important thing to try to become familiar with.

So, next slide?

This is another commentary by Hoge that I really thought made a lot of sense. I've seen it in other contexts too. But in terms of this engagement and rapport, conceptually in PTSD within an occupational

context that's much broader than the clinical definition, so it's not as much saying, "You have this disorder, PTSD," but understanding that some of these symptoms are highly adaptive in combat – so hyperarousal, hypervigilance, aggressive reactions, being able to shut down emotions, function on limited sleep. So these are the things we call PTSD – which they are symptoms of PTSD. But these were things they kind of had many of them to do if they were in combat.

And so it's just a shift in how you might conceptualize it that's may be more acceptable or feel more comfortable for some. I like using the Battle Mind Training Model, which was developed by people at the Walter Reed Research Training Center. But they basically take this approach and talk about the positives of some of these – emphasizing the inner strength and so forth – and that some of these things actually sustained their survival. But having that what they call battle mind might be hazardous to your health in the home zone. So they really emphasize that tradition. I've used it, and I think it can connect well with some.

So, next slide?

That's another point – there are brochures that are available. I think they've shifted this program into something that's broader now, which is resiliency training. But you can get ahold of the brochures and then just simply use them with individuals, particularly with those who are back fairly recently.

So, the next slide?

So this issue about social support and stress – these are probably obvious, but worth stressing. There is a strong tendency, among those who have PTSD for sure, to isolate; and that can start early, and then it can become self-perpetuating. So it's really important to monitor that I think and encourage contact with others. Sometimes that may be the best bet – is somehow try and encourage contacts with other veterans, whether through groups. There's a lot of new movement in the peer-to-peer support, which I think is great. There are even some online things that work with peer-to-peer support. So I think somehow trying to stay on top of the isolation because as we see, if it continues it just gets harder and it perpetuates some of the other symptoms.

Just another point, if you're fortunate enough to have referral for case management, that's so important because a lot of them are struggling with these issues; and it can make it really difficult to focus on the PTSD with the depression and so forth.

So let's see, next slide?

So what about the recommended treatments for PTSD? You're probably all aware that the VA and the Department of Defense have issued Treatment Guidelines, which have a lot of great information in them and recommendations. The VA in particular is providing training in prolonged exposure and cognitive processing therapy; so those two are the trauma-focused treatments that are out there that are getting a lot of attention and a lot of training. But we know that they sometimes need to be flexibly applied. Not all veterans are willing or immediately available to do the trauma-focused work. So you do your best to encourage them, but it may just not fit for some.

So, next slide?

This is again another study. I'm citing Hoge again, but I like this conceptualization of core components of recommended PTSD therapy. So rather than saying, "You've got to follow this protocol," he sort of says, "In all these recommended PTSD therapies, there are certain key core components," – psychoeducation obviously, but then there's the trauma-exposure narration. It's that dealing with the trauma, the emotional processing of the trauma, which is a key core component. There is the cognitive restructuring aspect, however, that is done – whether it's maladaptive beliefs or "stuck points" as they're called in cognitive processing therapy.

There is *in vivo* exposure – so getting out there and actually going to the places that have been avoided. And then there's this whole aspect of skills training which can be relaxation training, coping, and so forth.

So, next slide?

So my feeling is, if the person is willing and able, I will do the trauma-focused treatment as the protocol describes. And I'll encourage it, but clearly you've got to respect the veteran's judgment. You might want to think about multiple options for exposure work — so clearly like written or imaginal. You may want to vary the timing and order of different components; like you may want to spend a lot of time on some of the skills training before you go into some of the exposure work.

Next slide?

I'm moving quickly now, but marital issues – clearly big issue as we saw. And I think even at the simplest level, to provide psychoeducation regarding the very common post-deployment issues and tips on how to deal with them to spouses can be really helpful. And again, there's that battle mind; there's one designed especially for spouses. There's also some great information on the National Center for PTSD website that provides the information for family members, spouses and so forth and makes some recommendations. And I think that it really can be helpful -- just on a simple level, again, recognize and validate stress that the spouse has experienced. If there are spouse support groups around, I think they can be great.

So this is all kind of trying to increase the understanding and take some of the pressure off, which are sort of minimal steps to take. But in some cases, people may need more direct marital treatment.

I think on the next slide?

So just mentioning that there is some work that's going on looking at a treatment approach that simultaneously addresses the PTSD and the relationship issues, which they think has a lot of applicability to this population. And it has been used actually in veterans in the past. So it's something that I think we'll probably see more of in the future – is more work in development on these kind of treatments that try to do both at the same time.

So let's see, next slide?

Okay, and guilt – I felt like I needed to say something about guilt. It's kind of like I think an issue that is extremely important, very common, and has historically not gotten as much attention as some of the other aspects like anger and aggression or anxiety and PTSD. So I'll just use this quote that frames the context: It's, "reluctant to admit that essentially war is the business of killing..." (while the soldier himself) comes from a civilization in which aggression, connected with the taking of life, is prohibited and unacceptable."

And I think that says it all. That's part of the huge conflict in coming back. And certainly you see that guilt can be a very big issue, and it can be something that people really struggle with.

So, next slide?

So what's out there for treating guilt? There's some great work by Kubany back in the early 1990s, which is on the reference list where he really just developed this guilt typology and developed a cognitive model for working with some of these different kinds of guilt.

And then the next slide?

And there is actually work going on by some folks in San Diego where they've developed a preliminary manual trying to incorporate those principles and use it. So I think it's another area where there's more work developing, but there are some good materials out there that can help deal with the issue of guilt.

Next slide?

That's just a little bit more about the trauma-informed guilt reduction, which I won't go into detail here.

So, next slide?

And so this is another resource that I have found personally very useful. There's this model that was developed by Brett Litz and his colleagues where he talks a lot about – he uses the term moral injury and moral repair. It's just a different term, but it's getting at the same point. So there's really an excellent article that describes some of these issues and their outline of their treatment approach to try to deal with what they call moral repair, which includes both processing of incidents and exposure to corrective life experiences. So again, it's on the reference list; and I'd kind of recommend it.

#### Next slide?

Just mentioning work going on as well in terms of treatment of anger -- this is some of my work, which I'd be happy to talk about at any point.

It's time for me to conclude here. So the main point I'd make is these things are common. It might be more common among National Guard and Reserve veterans. The most important point is we've come so much farther in the last 20 years in terms of understanding and treatments, but we really need to keep working on innovative ways of engaging, treating and supporting these veterans. I think it's just really, really critical.

And with that I will stop. And thank you for your attention.

Thank you, Dr. Shea. And if you have any questions for Dr. Shea, please submit them via the Question Box on the Adobe Connect. So thank you for that.

A little background on myself -- I am the Outreach Chief here at DCoE. And prior to that, I worked at the VA System of Care as one of the Polytrauma Case Managers; and prior to that, I was a MICM Case Manager; and prior to that, I was a United States Marine for 16 years combat.

Thank you, Dr. Shea, for your great efforts working with our returning combat vets.

So I'm going to over a few of the tools that are available for our service members and also families and most importantly, the clinicians that treat them.

So as a disclaimer, as Dr. Shea said, I have no relevant financial relationship and do not intend to discuss the off-label/investigative (unapproved) use of commercial products or devices.

One of the things I'm going to go through first is our VA/DoD Clinical Practice Guide for Management of Posttraumatic Stress Disorder. And today I'm happy to announce that we have a tool that is useful for our providers; and that is our toolbox for treating Posttraumatic Stress Disorder. It accompanies the 2010 VA/DoD Practice Guidelines for Management of Posttraumatic Stress.

It provides the medical behavioral professionals with a useful, quick reference guide for treating patients with Posttraumatic Stress Disorders and related issues.

We also have other tools that are available: Understanding Posttraumatic Stress, and those are for patients and families; Experiencing Posttraumatic Stress Disorder as a Family: A Guide to Thrive, and that's for our family members; and like I said, for our health care providers, our VA/DoD Essentials for Posttraumatic Stress Disorder: Provider Tool; and like I just mentioned, our Posttraumatic Stress Disorder Pocket Guide. It's a great resource to get online, and you can look at that; and Implementing the DoD/VA Clinical Practice Guidelines, and that's the one that works hand-in-hand with our pocket guide.

And you can download the electronic version of the Clinical Practice Guidelines and any clinical support tools. Just go right to the websites listed on this slide: <a href="www.qmo.amedb.army.mil">www.qmo.amedb.army.mil</a>. To order hard copies of the CPGs, they won't be available 60 to 90 days out. But they will be available at the <a href="www.qmo.amedb.army.mil">www.qmo.amedb.army.mil</a>.

So again, thank you; and it's time for our questions and answers from the audience. So we are monitoring the Question Box and have forwarded questions to our presenters for a response. If you have not already done so, you may submit the questions via the box located on the screen.

And, Dr. Shea, we have a couple questions for you already, right off the bat. The first one is: Is there any data, more recent than Hoge, regarding the stigma that would give insight on the effects/military attempts to address stigma?

Just to repeat that question, is there any more recent data than the Hoge 2004 data on stigma or the attempts to address the stigma?

Right, that the military is doing.

The only thing I can cite in that regard is the more recent study by Kim and colleagues where they also assessed very similar items of stigma. And the numbers were lower, the proportions that were reporting the stigma positively did the stigma items was smaller. Whether that's due to military interventions, I can't say; but it does look like from the later studies that it's kind of going in that direction.

Great, thank you. Another question came in: How many National Guard and Reserve had integration issues prior to deployment? I suspect many already had these issues – not caused by deployment but caused by societal stressors, keeping jobs, etc.

Yeah, I think that's a really important point; I didn't really speak to that. And I think that some of the early studies, again by Hoge and some of the others – maybe Thomas -- they actually did assess predeployment rates using the same measures – the frequency of PTSD, I believe, as they measured it and compared – that's reported in that 2004 article at any rate and comes out somewhere I think about 5% or 6% reported. Now, was that due to any other deployment or was that just due to other things in life? And we know that having a history of any kind of psychiatric disorder, depression, anxiety and so forth puts people at higher risk of getting PTSD. So clearly, there's important influence of how people walk in to these deployments.

But I think the studies have shown that you can attribute clearly -- the rates after deployment are higher than they were before. Probably most of it is due to the deployment; but clearly, that's an important consideration.

I think some of the data too is showing the relationship between the severity of the trauma exposure and reporting screen positive also speaks to that level of impact. But again, some people are more vulnerable. Even if they don't go in with these disorders, they're going to be more vulnerable, based on prior experiences, to developing PTSD. So I think it's really important to always keep that in mind – to kind of look at a life history and understand that there are other traumas that people have experienced, other issues in life. And you can't say that all of this is due to trauma exposure.

Great, thanks. And we had another one come in: What is the best timeframe for PTSD assessment?

The best time for PTSD assessment – one of the things that seems to have been learned from some of these studies is that it's certainly not immediately after return from deployment. The speculation that people were either not experiencing the symptoms at that point, or possibly that they were minimizing them because they didn't want to have to be held up and assessed or be delayed because they're reporting symptoms. And that's why they've instituted the later assessment.

I think that a large majority of actual PTSD cases at least develop I would say – I think – within the first 6 to 12 months. There are cases of later onset, but I think they're pretty unusual. So I think certainly making sure that people are followed at least three to six months – maybe up to a year – following deployment you should probably get a pretty good handle on most of the people that are likely to have problems. I think they'd probably be showing signs of it by then.

Great, thanks. What aspects of social support are key?

Ah, this is an interesting question too because social support has multiple dimensions. I can't say, based on what I have read and what I'm familiar with, if anybody's actually looked at the specific components of social support – whether it's the emotional, whether it's the practical aspects of social support. So it's an interesting question.

I think one finding that we had from the study that I was talking about for the National Guard sample was that we looked at risk factors or predictors of developing or having PTSD. And one of the strongest predictors aside from exposure was life and family stress during deployment. And so that says something to me. And also stress and social support after deployment were predictive. But it said something to me about maybe some of the possibly practical aspects of social support too – that if one is during deployment worrying about what's going on at home and not feeling that they have the resources to address it – whether it's financial, whether it's the kids acting out, what have you – that could create the kind of stress that perhaps again increases the risk for having trouble down the road.

So it's a good question. I can't give a definitive answer to it.

So we just had a really good one come in: What are your thoughts on the National Guard and Reserve who have been deployed in terms of identifying with the military versus identifying with their civilian life -- thinking of working with these men and women in therapy but also referring them to resources?

So the degree of identification with the military as opposed to civilian life – that's an interesting question as well. And it's interesting as I'm just reflecting on my own experience that some of the people I see do seem much more identified with civilian life; and others have a very strong ethic of the military -- the National Guard, the deployment. I hear also a lot of people who want to go back. There's a sense of identification there that can sometimes even get more powerful I think with additional deployments – probably other reasons and things that go on there as well.

But in terms of referral – was that part of the question too? Like how that might impact referral? Like whether the identification is stronger with the military versus civilian?

Actually it says: Thinking of working with these men and women in therapy, but also referring them to resources.

But also referring them to resources.

Because they're not on the military bases.

Because they're not on the military base, yeah – well, it's a very interesting question. I think that regardless of where their strongest identification is, it seems to me based on my experience that the effects – at least the people who are coming in, and that's who I see obviously and that's who we all see – but that the effect of the deployment itself is strong enough that there is a need to really feel like people get it. And so I think that speaks to the need for whether it's a civilian provider, whether it's a veteran provider, which a lot of folks really feel comfortable with because they feel like they get it – but that that acknowledgement and that ability to provide some sense of understanding is key, whether they identify more with civilians or not because I think the deployment experience is clearly very powerful for the ones who are coming in. So I hope that answers the question. I don't know if it does.

I think so. And then here's one that kind of piggybacks on that: Balance studies that focus on Guard and Reserve mental health data is hard to find. Having completed this effort, what would you recommend for any follow-up work?

Oh, these are good questions. I think that I would say off the top of my head that what I worry the most about is, again, getting people into treatment – so studies that can continue to address how to overcome the obstacles and improve the access rate are really important. And then also work that identifies ways to keep people in is important because right now, as we saw from some of that data, it appears to be just a minority that are actually getting in early and getting enough sessions to receive intensive treatment, at least for PTSD. So I think those are still key areas that we've got to follow up.

And the other thing I think that we need – we have good treatments now and we've made huge advances; but I think we need to keep working on improving treatments. Our current ones, they don't work for everyone. There are some people who might get some improvement, but it's not complete. I mean, they may still meet treatment for PTSD. They might be struggling with other things.

So I think that's another area that I'd really recommend. But just again going on to further work, I think somehow if people are coming to the VA, that's one thing; that's an integrated health care system. But outside of the VA, I think that the health care system is kind of confusing probably. It's even confusing at the VA. But somehow to be able to get information to people about how to get treatment in a way that isn't complicated and that really moves them right into it is another thing that's part of our sort of non-VA health care system. So I guess that's what I'd say.

Well, here's another one; and it kind of piggybacks on that, especially with the mild TBIs being so prevalent. I hear a lot it's the signature injury of the war. What special considerations are most successful in treating mild TBI patients for PTSD? TBI and cognitive disorders seem to be complicated therapies that might otherwise produce higher and earlier improvements?

So is the question about how mild TBI might be influencing treatment outcome?

#### Right.

I think we need more research on that. I have seen at least one study I think that included people with mild TBI and felt that the treatment – I think it was prolonged exposure – was just as effective and was effective for those folks. But that's one study. And I don't really know. I think within that kind of diagnosis, there's a range I think in terms of how the TBI is affecting cognitive functioning – at least that's been my experience. So I think the key is probably the extent to which the person can sort of cognitively process what is going on in the treatment. And I think that most of the cases at least that I've seen that have mild TBI, they can. I think it's when they can't you're getting into the more severe, what you probably wouldn't call mild TBI. So I think they may need more help trying to stay organized and make the appointments and so forth. But I think most of them, the treatments probably will apply.

Thanks, and I think a lot of that comes about to when you have a team effort treating that service member or veteran – that multidisciplinary team where you have that polytrauma working hand-in-hand with the mental health clinic, I think you have better outcomes.

Yeah, I think that's an excellent point.

Here's another question: Have there been any studies which look at the effect of differences in social networks – the camaraderie, the team cohesion, time spent outside the workplace – between the National Guard and Reserve and the regular service members before and after deployments as related to PTSD, depression and other mental health issues?

So are there studies that have actually looked at the amount of support within units rather than just speculating that that is a bigger problem?

Yeah, when they go back to their hometown, they're not with their comrades that they served with a lot of times as the regular service members that come back.

Yeah, I am not aware of any studies that have actually measured that; but it's a very interesting question.

Okay, we have one last question: In suggesting how to deal with PTSD treatment and engagement and rapport, are you speaking to military Tricare providers or civilian providers, including the primary care providers or only mental health providers?

Oh, I think all of the above. I think any clinician that is working with these folks gets as familiar as they can, but also understand what they don't understand. And that goes to all of us – being able to recognize that there is a certain aspect of an experience that if you haven't been there, you don't know. But I think that anybody who is able to convey that they've paid attention and they have some knowledge and that they're also listening, I think that that can go a long way.

Well, a lot of it is getting over the fear of, "I don't know and I need to find out," – especially providers. It's a continually moving environment, and you have to keep up.

Yeah, I personally think – and people who do therapy know this – being open to listening and learning goes a long way in terms of establishing rapport versus feeling like you have to have all the answers.

Absolutely, don't be afraid to refer out if you don't know the answers.

And again, thank you, Dr. Tracie.

Oh yeah, thank you. It was my pleasure.

Today's presentation will be archived in the monthly webinar section of the DCoE website. To access the presentation and resources listed at the webinar, visit the DCoE webinar at <a href="https://www.dcoe.health.mil/webinars">www.dcoe.health.mil/webinars</a>. An edited transcript with closed captioning will be posted to that link. Also an audio recording of the webinar will also be available as a downloadable podcast.

To help us improve future webinars, we encourage you to complete the feedback survey. This link is available on the DCoE website also.

And don't forget, and thank you again for attending today's webinar. And the next DCoE webinar topic is Violence Risk Assessment, and it's scheduled for June 27<sup>th</sup>, 2013, from 1300 to 2030; and that's on Eastern time.

Thank you again and have a great day.